Nottinghamshire Area Prescribing Committee Meeting minutes

APC meeting 16th December 2021, due to the COVID-19 Pandemic the meeting took place as a web conference using Microsoft Teams.

All attendees should be aware that public authorities are legally required to comply with the Freedom of Information Act 2000. The minutes and papers from this meeting could be published on the Publication Scheme or internet with all names included, unless notified to the Chair before the meeting commences or included in a pre-agreed confidential section due to the sensitive nature of the topic.

Present:

Steve May (SM) Chair	**Chief Pharmacist**	**Sherwood Forest Hospitals NHS Foundation Trust**
Tanya Behrendt (TB)	**Senior Medicines Optimisation Pharmacist**	**NHS Nottingham & Nottinghamshire CCG**
Laura Catt (LC)	**Prescribing Interface Advisor**	**NHS Nottingham & Nottinghamshire CCG**
Esther Gladman (EG)	**GP- City ICP**	**NHS Nottingham & Nottinghamshire CCG**
Tim Hills (TH)	**Assistant Head of Pharmacy**	**Nottingham University Hospitals NHS Trust**
Susan Hume (SH)	**Advanced non-medical prescriber**	**Nottinghamshire Healthcare NHS Foundation Trust**
Jennifer Moss Langfield (JML)	**GP**	**LMC representative**
David Wicks (DW)	**GP**	**Mid Notts ICP Nottingham & Nottinghamshire CCG**
Sarah Northeast (SN)	**Advanced non-medical prescriber**	**Nottingham CityCare**
Clare Nowak (CN) representing ME	**Deputy Chief Pharmacist**	**Nottinghamshire Healthcare NHS Foundation Trust**
Katie Sanderson (KS)	**Patient representative**	
Ann Whitfield (AW)	**Patient representative**	

Interface support:
Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFH (from 3pm)
Hannah Godden (HG), Specialist Mental Health Interface Pharmacist, NHS Nottingham & Nottinghamshire CCG
Jill Theobald (JT), Specialist Interface Pharmacist, NHS Nottingham & Nottinghamshire CCG
Michalina Ogejo (MO), Medicines Optimisation and pain clinic Pharmacist

In attendance:
Jo Freeman (JF), Assistant Chief Pharmacist, SFHT attended at 14:30hrs for the steroid card agenda

Michelle Haigh, Medicines Optimisation Pharmacist, NHS Nottingham & Nottinghamshire CCG

1. Apologies:

Asifa Akhtar (AA) GP, South Notts ICP, NHS Nottingham & Nottinghamshire CCG
David Kellock (DK), SFH Drug and Therapeutics Committee, Sherwood Forest Hospitals NHS Foundation Trust
Ankish Patel (AP), Head of PCN Workforce
Khalid Butt (KB), GP Mid Notts and LMC representative

2. Declarations of interest (DOI)

None declared.

3. Minutes of the last meeting/matters arising

The minutes from the previous meeting were reviewed and were accepted as an accurate record of the meeting subject to the correction of some minor typographical errors.

Ibandronic acid for adjuvant treatment of breast cancer
TB informed the committee that the business case had been submitted but no further update was available. It was agreed that the Cancer and Commissioning leads should raise this for Exec sign off and that TB and TH had done all they could to support.

ACTION: TB to re- send a chasing email to request an update from CCG commissioning.

Toculizumab in pregnancy and neonatal vaccines
JML had investigated this and discussed with obstetrics who have given assurance that they are aware of the issue and have a process in place.

Diabetes Guideline update- options paper
The options paper and recommendation from last APC was fed back to the diabetes working group. A business case was being developed to request an interim guideline update with approval of associated increased prescribing cost while the NICE update is awaited. LK and LC have inputted into the costing section of the business case.

ACTION: LK and LC to feedback following the CCG decision on the business case.

Sativex and traffic light status
No further progress on a submission through NUH DTC or a change to the tariff status currently.

ACTION: TH to follow up this issue and bring back to APC if required

Amiodarone shared care
There was an on-going query about how the labs at the acute trusts report TFTs and therefore what should be recommended on the shared care protocol. It was clarified that SFH will test on exactly what is requested.
The RMOC standard shared care template for amiodarone has been delayed but is expected to be published in spring.

ACTION: SW to review the RMOC documentation when published and update the local guidance as appropriate at that point. Minor points of accuracy around testing TFTs can be updated in the interim.

Lithium shared care protocol
HG confirmed that there is no mandate for Area Prescribing Committees to adopt RMOC shared care protocols locally or change traffic light classifications. Lithium traffic light classification and possible shared care has been discussed at this meeting previously and it was agreed to remain as Amber 2.

Fentanyl Patches and brand choice
MO explained that due to current capacity the pain management guideline and oxycodone switches had been put on hold until early next year. The PCN pharmacy team will be asked to help with this work.

ACTION: MO to pursue a switch in primary care to Opiodur®.

Vectura inhalers
BTS have issued a statement recommending discussion with the patient. This can be found here. There was no further update for APC to consider.

Inclisiran
TB informed the group that the national lipid management flow chart was now updated to include inclisiran. This is to be circulated for information and approval is to be sought from lipidologists to replace the local version with this one. Following this replacement inclisiran would be updated from Amber 2 to Amber 3 in line with agreement at the last APC meeting.

ACTION: TB to circulate the updated guidance and seek approval from specialists. Once approved this version will be uploaded in place of local guidance and the formulary updated.

Trimbow NEXThaler
This had been agreed for addition to the formulary with an Amber 3 classification at the last meeting. However, as the COPD guideline lists individual devices, this also required updating. The authors of the guideline had confirmed that they were happy with the addition of Trimbow NEXThaler and the APC agreed for this minor amendment to be made without further review from the APC.

ACTION: LK to upload updated COPD guidance to APC website.

****Other actions were completed or on the agenda for today's meeting****

4. DOAC national rebate scheme (LC/TB)
LC informed the group of a national rebate on some of the DOACs whereby a payback from the manufacturer would be given to the CCG via NHS England according to items prescribed. The most cost-effective choice of DOAC when the rebate is taken into account will be edoxaban which is in line with our current position statement to select this first line as long as all clinical factors had been considered first.
The Medicines Optimisation team had reviewed the national rebate compared to current local ones and concluded that moving to the national scheme is most cost effective.

ACTION: LC to update the committee when the national scheme begins and the interface team to review any APC documentation which may need amending.

5. APC Terms of Reference (ToR)
LC presented the updated ToR. There were slight changes as PCN's were now represented. JML suggested this should be an interim update as further amendments would be required once the ICS

is formed.

ACTION: LC to upload the updated version with a 6-month review date and revisit the wording following formation of the ICS

6. Steroid card guidance

JF attended the meeting to discuss the steroid card guidance following several comments and queries when this was presented last time. JF explained that this was based on national guidance and the authors agreed some of the content wasn't ideal and that a paper based alert card had several flaws.

ACTION: JF to finalise and send to LC for uploading. However, it was noted that the MSO group intend to do some further work on the document so the current version should be uploaded as an interim guide.

7. Melatonin prescribing update

HG presented an update on melatonin prescribing data with comparisons to other regions where available. Within the East Midlands, the Nottinghamshire secondary care providers were the highest with regards to melatonin spend and items prescribed over the last 12 months. Nottingham and Nottinghamshire CCG primary care spend on melatonin is significantly lower than other CCGs in the region and the 10 most similar CCGs. It was explained that this is because most of the melatonin prescribing is done in secondary care in Nottinghamshire. Nottinghamshire appears to be an outlier in terms of the red formulary traffic light status for melatonin prescribing in paediatrics; in most other areas it is shared care or amber 2. It was highlighted that Nottinghamshire formulary recommends unlicensed products alongside Circadin® for paediatrics; most other areas have moved to recommending licensed products in this cohort. If the secondary care and primary care prescribing data is added together, melatonin prescribing costs in Nottinghamshire are in the median of the 10 most similar CCGs.

TH highlighted that historically clinicians in Nottinghamshire wanted to use the unlicensed capsules as they are immediate release. There is now a licensed immediate release 3mg tablet (licensed for jet lag) that is more cost effective than Circadin® which could be considered.

LC highlighted that the APC melatonin guidance published doesn't appear to have reduced volume of melatonin prescribing in paediatrics. SM highlighted that wasn't necessarily the expectation as clinicians have always claimed to be working in that way anyway.

TB highlighted that prescribing costs and volumes are low in Northampton CCG. However, it's difficult to make accurate comparisons when we don't know their level of secondary care prescribing. NUH are doing lots of work around melatonin reviews and there are concerns about if this would happen to the same level in primary care. Due to gaps in the secondary care prescribing data for other areas, it's difficult to establish whether Nottinghamshire are high prescribers of melatonin or not.

Action: HG to contact Northamptonshire CCG to establish their practice in terms of melatonin prescribing in paediatrics

8. Insect bites and stings

A request had been made for an insect bites and stings guideline. SW had produced two versions in consultation with Dr Weston. One contained the antibiotic recommendations for insect bites with signs and symptoms of infection in a tabular form to aid the prescribers, but this was not favored by

Dr Weston due to the risk of giving the antibiotic as a default and not reading the context. This was also agreed by the APC. A request was made for it to include some pictures of bites to show the difference between infected and allergic bites. JML showed example pictures to the group and recommended dermnet.nz website to obtain more.

ACTION: SW to incorporate the images to version one and upload

9. Omeprazole liquid for children

JT presented a guideline for review of children and young people on long term omeprazole liquid. The annual spend for omeprazole liquid is in excess of £400,000 and the aim of the guideline is to facilitate review to enable discontinuation or switching to a more cost-effective formulation if appropriate.
Mezzopram was agreed as the preferred cost-effective brand for omeprazole dispersible tablets.
EG highlighted that rebound hyperacidity can occur after sudden withdrawal of PPIs and asked that a line be added to advise weaning down dose slowly over a few weeks.
EG asked if it was necessary to do blood monitoring to detect magnesium and B12 deficiency. JT to find out if this is necessary and make the guidance clear as to what monitoring is required in primary care.
JML suggested listing lansoprazole above omeprazole for oral administration in children >10kg. Lansoprazole is used off label in children, whereas omeprazole is licensed. However, lansoprazole is commonly used in children as per national guidance (BNFc). JT to discuss with secondary care paediatric pharmacists.
The guideline was approved pending resolution of the issues raised.

ACTION: JT to resolve the issues raised via email, make changes, then upload to APC website.

10. Gastroprotection and Antithrombotic Guide

LC presented this guidance which had been developed by NUH and had been ratified internally there. It was felt this was a helpful guide so should be hosted on the APC website for wider use. It was based on Pincer indicators which identify patients prescribed antithrombotics and antiplatelets without gastroprotection and guides the prescriber to consider adding such protection.
The guidance was well received but it was requested that the APC logo and version control be added.

ACTION: LC to finalise the document and upload to the APC website

11. Linaclotide Information sheet

LC presented a new prescribing information sheet for linaclotide which replaces an out-of-date flow chart which was linked from the formulary entry. This had been developed by one of the Medicines Optimisation pharmacists and had been circulated to specialists including the community continence team for review. The information sheet was based on the SPC.
Changes to the formulary entry were also presented with the main ones being the removal of the restriction for only gastro consultants to be able to initiate and for the 4-week review to be conducted by the initiating clinician ahead of transfer to the GP.

ACTION: LC to upload the document and make the agreed formulary changes.

12. RMOC update

TB circulated a summary following the last meeting and the next RMOC meeting is in January.

13. Formulary Amendments and Horizon Scanning

Traffic light changes:

- **ActivHeal Hydrogel** – added as GREEN
- **Aripiprazole short acting injection 7.5mg/mL (Abilify®)** and **olanzapine short acting injection** – both injections added as RED for use at Nottinghamshire Healthcare in line with trust rapid tranquillisation policy.
- **Barrier preparations** updated on formulary in line with last update of barrier formulary.
- **Bimatoprost/ timolol PF eye drops (Eyzeetan®)** – AMBER 2 to replace Ganfort PF UDVs which are now GREY.
- **Casirivimab/ imdevimab solution for injection/infusion (Ronapreve®)** - RED
- **Diflucortolone valerate 0.1% & 0.3% cream, ointment, oily cream (Nerisone® & Nerisone Forte®)** - previously discontinued but available again. Remain GREY non-formulary as more cost-effective preparations available.

ACTION: Remove the word "discontinued" from the existing GREY formulary entry

- **Memantine 10mg/mL Oral Solution** – added as AMBER 2, most cost-effective option for patients unable to swallow tablets.
- **Omeprazole dispersible tablets (Mezzopram®)** – GREEN, replaces Losec MUPS as preferred brand of omeprazole dispersible gastro-resistant tablets.
- **Pimecrolimus 1% cream (Elidel ®)** and **Tacrolimus 0.03% and 0.1% ointment (Protopic®)** - traffic light request to amber 3. Agreed to leave as AMBER 2 for eczema and facial psoriasis, but GPs with a special interest can initiate in line with the APC psoriasis guideline and NICE TA82.

ACTION: Update APC psoriasis guideline and add note to Joint Formulary that GPs with special interest can initiate

- **Potassium citrate with citric acid effervescent tablets** – AMBER 2 for patients with recurrent kidney stones. Remains RED for other indications.
- **Salbutamol inhalers** – move to lower carbon footprint choices.
    - **1st line: Salbutamol *Easyhaler***: For patients for whom a DPI is appropriate.
    - **2nd line: *Salamol* Inhaler + spacer**: For patients for whom an MDI is appropriate (note this is the press and breathe MDI, **not** the breath-actuated Salamol EasiBreathe).
    - **3rd line: *Salamol EasiBreathe***: For patients for whom a breath-actuated MDI is needed.

ACTION: Update formulary and create OptimiseRx messages to prompt prescribers.

- **Sodium hyaluronate 0.2% (Eyeaze®)** – GREEN, to replace Hydramed® as preferred brand in the eye lubricant formulary (more cost effective).
- **Sodium hyaluronate 0.2% (Hylo-Forte®)** - AMBER 2 – specialist recommendation for severe dry eyes if Eyeaze® not suitable. Secondary care ophthalmologists requested that Hylo-Forte® remains available due to its higher viscosity.

- **MHRA: Neutralising Monoclonal antibody sotrovimab (Xevudy®)** – Will be available for use as a first line treatment for non-hospitalised patients from 20th December 2021 for COVID-19 patients who are PCR positive, age 12 years and above, and who are considered at higher risk of progression to severe disease, hospital admission or death. It was noted that this had not yet been reviewed by NUH DTC, but due to time pressures it was felt appropriate to classify it for formulary inclusion.

  ACTION: Classify as RED and follow up with NUH DTC.

Discontinued products:

- **Amisulpride 100mg/ml oral solution (Solian®)** – brand removed, still available generically.
- **Aquaform Hydrogel** - GREY non-formulary
- **Calcium carbonate effervescent tablets (Cacit®)** – brand removed, still available generically.
- **Diazepam 2.5mg Rectal Solution (RecTubes®) –** Brand not specified on formulary; alternative products available.
- **Dithranol (Dithrocream®)** - Removed 0.25% 0.5% & 1% strengths as discontinued. 0.1% remains, but will be discontinued in Oct 22.
- **Dithranol (Micanol®) 3% cream** - GREY non-formulary
- **Farco-Fill Protect®** – GREY non-formulary
- **Testosterone (Restandol®) capsules** – GREY non-formulary

Other changes or items for further consideration:

- **Fluoride enriched toothpaste** - Significant amount of toothpaste prescribing taking place in primary care. Joint Formulary currently does not give a clear duration of treatment, although specialists have indicated that this is usually long-term. Maxillofacial team advises patients about the importance of registering with a dentist for regular review/treatment as necessary and to obtain prescriptions of the fluoride enriched toothpaste from their dentist. Letters are also sent to the patients' dentist after every appointment with the hygienist and on discharge.

ACTION: Add a note to the formulary that GPs should not prescribe fluoride enriched toothpaste unless in exceptional circumstances (e.g., where a patient is struggling to find a dentist. If this is the case, it can be prescribed as an interim measure until the patient registers with a dentist).

Pabrinex® IM Injection – request to change from Amber 2 to Amber 3 classification. The committee requested more information about observation times and patient cohorts. It was discussed that the traffic light reclassification might help to improve access to IM Pabrinex for certain patient groups in the County (e.g., homelessness) who will not engage with specialist services. JML highlighted that Amber 3 classification could put pressure on GPs to prescribe when specialist substance misuse services are better equipped to meet the needs of these patients. JML also highlighted that a traffic light reclassification to Amber 3 could be perceived as shifting workload to GPs and gaps in specialist services in the county should be addressed rather than relying on GPs to fill that gap. JML queried whether an observation period was required after IM Pabrinex administration.

ACTION: HG to liaise with specialists and email APC members for a final decision

Horizon scanning:

- **Added as GREY no formal assessment:**
  - Baloxavir marboxil tablets (Xofluza®▼)
  - Bioidentical estradiol and progesterone 1mg/100mg (BIJUVE®)
  - Budesonide 160micrograms / Formoterol 4.5micrograms (WockAIR®)
  - Cenobamate tablets (Ontozry®▼) – awaiting NICE TA
  - Levonorgestrel IUS (Benilexa® One Handed)
  - Olopatadine / mometasone (Ryaltris®) nasal spray
  - Peanut protein as defatted powder (PALFORZIA®▼)
  - Relugolix / estradiol (as hemihydrate) / norethisterone acetate (Ryeqo®▼)
  - Semaglutide prefilled pens (Wegovy® – US name) for weight management

  - Standardised allergen extract of pollen from white birch (Betula verrucosa) 12 SQ-Bet* per oral lyophilisateoral lyophilizate (Itulazax®▼)
  - Tafluprost (Saflutan®)
  - Tiotropium bromide 18micrograms inhalation power, hard capsules (Acopair®)
  - Tirbanibulin ointment (Klisyri®▼)
- **For noting:**
  - Rivaroxaban generic preparations expected in 2023
  - Berotralstat capsules (Orladeyo®▼) - TA738 reviewed by NUH DTC and RED classification given NUH only.
  - Molnupiravir 200mg capsules (Lagevrio®▼) – Had been reviewed by NUH DTC and classified RED for delivery by a specialist covid medicines delivery unit (CMDU) service.

14. <u>New applications</u>

- **Trimbow® inhaler for asthma**

The JFG had discussed a request for Trimbow® pMDI with an Amber 2 classification for use as maintenance treatment for asthma in adults in line with its licensed indication. SW explained that Trimbow® pMDI was useful in patients already on MDI, particularly Fostair® that need a step up of their asthma treatment due to inadequate control. It was highlighted that switching to Trimbow® pMDI was an advantage over adding Spiriva® respimat device as the LAMA component to the ICS/LABA combination, as further inhaler counselling with a nurse or a pharmacist is not needed. Additionally, controlling asthma without having to use a high dose inhaled steroid will be predominantly beneficial to the niche group of patients with asthma symptoms of breathlessness on exertion, not exacerbating that often and not particularly eosinophilic.

ACTION: Add to formulary with AMBER 2 classification for asthma in adults. Audit prescribing data after 6 months.

- **Safinamide**

The JFG had discussed a submission to extend the use of safinamide for off periods with *or without* dyskinesia as an adjunct to levodopa in Parkinson's disease. An updated flowchart to that seen at the JFG was presented. This incorporated clinical criteria (cognitive impairment, history of hallucinations and cardiac history) in addition to the permitted age group, which had been increased to patients greater than 70 years old. It was also highlighted that Nottinghamshire is the fifth highest prescribing CCG of safinamide in England and most of the practice-based prescribing was within the Mid Notts area. This suggested that SFHT likely initiated safinamide. This had been raised with the SFHT Parkinson's team and it was felt that wider prescribing was already happening in the Mid Notts area. This could mean that the expected number of patients that will be initiated on safinamide will be less than currently indicated on the submission by Dr Sare. Additionally, APC felt that having a guideline could help in decreasing safinamide usage by controlling the inappropriate prescribing from the outlier areas. Minor amendments to the flowchart were suggested.

ACTION: SW to liaise with Dr Sare regarding minor amendments to the flowchart. Once finalized expand permitted indication on the formulary with no change to the AMBER 2 classification.
LK to continue to liaise with SFHT team regarding local use of safinamide.

- **Lyumvjev® (insulin lispro)**

A formulary application had been discussed at the JFG for Lyumjev® (insulin lispro), a faster acting version of Humalog. The faster onset of action allows it to be given just before a meal and trials suggest that it may be more effective at controlling post-prandial hyperglycaemia. Lyumjev® is licensed for use in adult patients only. It is available as two strengths but only the U100 had been requested for use locally. Brand prescribing is essential to avoid inadvertent switching to standard insulin lispro. Lyumjev® is cost equivalent to current standard mealtime insulins, but concerns had been raised at the JFG, that its use could prevent the uptake of less expensive biosimilars in the near future. The submitter had confirmed that Lyumjev® would be used as a second line option for patients that were not achieving targets on standard insulins, which would be a different patient group to that in whom biosimilars would be considered. The JFG had suggested that Lyumjev® be restricted for antenatal patients, patients with an insulin pump and patients using a Freestyle Libre device where time in range can be measured and that it be restricted to consultant initiation only. From ePACT 2 data it had since been estimated that there are approximately 1300 adult patients using Freestyle Libre and this is likely to increase further. The APC agreed an Amber 2 classification in line with the JFG's recommendation and requested audit data be presented in 6 months' time. The U200 strength will be classified Grey.

ACTION: LK to update formulary and inform clinicians. LK to request audit data in 6 months' time

15. <u>APC forward work plan</u>
Noted

16. <u>AOB</u>

- **Shared care monitoring through COVID**

JT had received a request from primary care pharmacists to ask if shared care blood monitoring could be relaxed again to help with workload pressure during the current COVID wave. The committee felt that it would not save a significant amount of time and that patient safety must be considered first. However, if it could be done safely and with the support of specialists then it would help.
JML raised the issue of the recent shortage of sample bottles / tubes, but TB confirmed that shared care monitoring was priority and had not been relaxed as a result of the bottle shortage.
Post meeting note: The shortage of bottles is now resolved and all monitoring should be slowly returning to normal (see NHSE letter dated 29/11/21).

ACTION: JT to ask specialists about the possibility of temporarily relaxing shared care blood monitoring again.

- **MTX in pregnancy – Shared Care Protocol update**

Following an incident, the shared care protocols which include methotrexate will be updated to highlight the need for both the specialist and GP to complete regular counselling on appropriate contraception. Female patients must not become pregnant whilst taking this medication.

ACTION: SW to add changes to the SCPs (IBD, Rheumatology, and Dermatology) and upload.

- **Triptorelin**

It had been highlighted that the 6-monthly version of triptorelin could reduce appointments for administration and specialists were in agreement with primary care switching patients prescribed this for Prostate Cancer. This will be added to the Gonadorelin analogues position statement.
ACTION: KR to update position statement.

- **Pizotifen**

LK informed the committee that following the update of the adult headache guideline pizotifen had been removed from the formulary in February 2020. This was due to a lack of evidence preventing its inclusion in National guidance, rather than any safety concerns. It had been highlighted by paediatrics that some existing patients were experiencing problems obtaining prescriptions. A formulary submission had been requested if continued use in paediatric patients is desired, but it was suggested that the formulary be annotated to allow continued use in existing patients if appropriate. Paediatric dosing is contained in the BNFc and APC agreed.

ACTION: LK to update formulary.

- **Hypothyroidism in pregnancy**

The lack of clarity on primary care responsibilities for managing hypothyroidism in pregnancy had been raised at the last meeting. JML had discussed with SFH and NUH, but work on defining midwife and GP responsibilities for managing patients and developing primary care guidance is needed.

ACTION: Interface team to link with JML to move this work forward.

17. <u>Date of next meeting</u>

The committee agreed to postpone January's JFG meeting to allow time for focusing on the COVID-19 booster vaccine delivery programme. The next APC meeting will therefore be on 17th March 2022.

The meeting finished at 17:20 pm